



American College of Surgeons

ATLS® COURSE REQUEST AUTHORIZATION FORM

This form must be validated by the State/Provincial (S/P) Chair and the ACS ATLS® office for the course to be officially authorized and conducted. (Please type or use ballpoint pen to complete this form and forward to your S/P Chair.) The S/P Chair will forward all copies to the ATLS® office.

Shaded areas are for office use only.

Course Site City: <u>Billings</u> State: <u>MT</u> Country: <u>US</u> # <u>1773</u>		
Facility: <u>Mansfield Center</u> <input type="checkbox"/> This is a new course site.		
Date of Request: <u>#2/ 11/ 06</u> Course Dates: <u>11/ 17- 18/ 2006</u> Commercial Support Agreement Required? <input type="checkbox"/> Yes <input type="checkbox"/> No Commercial Support Agreement Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Course Type Course Closed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student - 2 day <input type="checkbox"/> Student - 2.5 day <input type="checkbox"/> Student/Student Refresher - 2 day <input type="checkbox"/> Student/Student Refresher - 2.5 day <input type="checkbox"/> Student Refresher - 0.5 day <input type="checkbox"/> Student Refresher - 1 day <input type="checkbox"/> Instructor - 1.5 day <input type="checkbox"/> Instructor Update (circle one) • 1 day course • Extended Precourse Faculty Meeting	Participants <input checked="" type="checkbox"/> MDs/DOs # of: <u>12</u> <input type="checkbox"/> Residents # of: _____ <input type="checkbox"/> Final-year Medical Students # of: _____ <input type="checkbox"/> Doctors-other countries* # of: _____ <input type="checkbox"/> Dentists # of: _____ <input checked="" type="checkbox"/> Physician Extenders Identify Type: <u>PA</u> # of: <u>4</u> <u>RN</u> # of: _____ <input type="checkbox"/> Student Refreshers Identify Type: _____ # of: _____ _____ # of: _____ <input checked="" type="checkbox"/> Auditors Identify Type: <u>RN</u> # of: <u>4</u> <u>EMT</u> # of: _____ * Contact ACS ATLS® if Instructor Course
First Director: <u>John Middleton MD</u> # <u>6965</u>	Second Director: _____ (If > 24 Students) Identification No.: _____ Specialty: _____ Candidate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Identification No.: <u>458-761785</u> Specialty: <u>GS</u> Candidate? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Qualified? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	Qualified? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	
National, Regional or S/P Faculty required to evaluate candidate(s): Name: _____ Identification Number: _____		Qualified? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ Faculty Level: _____
Educator: Identification Number: _____ Candidate? Yes <input type="checkbox"/> No <input type="checkbox"/>		Qualified? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____
Coordinator: <u>Jim DeTienne</u> # <u>76069</u> Address: <u>EMS + Trauma System, PO Box 202751</u> <u>Helena MT 59620</u> Telephone: <u>406-444-4460</u> Fax: <u>406-444-1814</u>		Qualified? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____
**Contact person for ATLS® web site if different from course coordinator listed: Name: _____ Telephone # _____		
ACS State/Provincial Committee on Trauma Chair's Coapproval		
<input checked="" type="checkbox"/> Course approved	<input type="checkbox"/> New Site Approved	<input checked="" type="checkbox"/> Physician Extenders approved
<input type="checkbox"/> Approved all participants	<input checked="" type="checkbox"/> Auditors approved	<input checked="" type="checkbox"/> Manuals approved
Signature: <u>#138506</u>		Date: <u>2-23-06</u>
ATLS® Office Coapproval		
Course Approved? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Course Serial #: <u>29048-P</u> By: <u>FS</u> On: <u>3/22/06</u>